



LETTER TO THE EDITOR

Antiplatelet therapy at discharge for Takotsubo syndrome: Could propensity matching and/or sensitivity analysis be of value?



Terapêutica antiplaquetária no momento da alta por síndrome de Takotsubo: pode a combinação do score de propensão e/ou da análise de sensibilidade ser importante?

I very much liked reading the contribution by Pereyra et al.¹ on the impact of antiplatelet therapy (APT), prescribed at discharge in patients with Takotsubo syndrome (TTS) in 544 patients from the Spanish National Takotsubo Registry (RETAKO Registry). The authors compared 321 patients who were prescribed APT with 223 patients who did not receive this therapy upon discharge. The two subgroups differed in that the APT patients had a better clinical presentation and had received angiotensin converting enzyme inhibitors/angiotensin receptor blockers, beta blockers, and statins, at a higher rate than the non-APT patients. Following adjustment of differences in the two cohorts, APT had a protective effect for all-cause mortality, recurrence of TTS, and hospital readmission at month 25 of follow-up. These findings are at odds with the results of another study,² which had not found aspirin to be of any value in patients with TTS. It is noteworthy that the other study² included follow-up extending to five years. The authors of the present study¹ provide reasonable arguments for a beneficial role of APT based on its influence in inhibiting platelet activation, and preventing inflammatory activity and endothelial dysfunction early in the course following TTS. This is supported by the secured follow-up of 25 months. Of course, one may argue that had the authors¹ extended the follow-up of their patients to five years, the same conclusions reported previously,² might have been reached. This does not detract from the authors' notion that APT is beneficial within the time limit of 25 months after an admission with TTS, and this can be a basis for a recommendation that APT should be

restricted only to the two years after the TTS event, except if there are other reasons for the patients to continue APT beyond this time point.

I would like to raise some issues for the authors' consideration: (1) Given the acknowledged limitations of the study, do the authors feel that there would be a merit in defining better the role of APT at discharge following an episode of TTS, by reanalyzing their data on the 544 patients, using propensity matching methods, or the patients of the entire RETAKO registry, employing posthoc sensitivity analyses?³ (2) Since the authors state that their data "refer to the population of Spain and therefore should be considered carefully before being extrapolated to other geographical areas",¹ I wonder since they reported a prevalence of diabetes of 16.1% and obesity of 16.5% in their RETAKO subanalysis for the APT study, what is the prevalence of diabetes and obesity for the general population, mainly for women at a mean age of 72 years in Spain, in light of previous reports that both diabetes,⁴ and obesity,⁵ may exert a protective effect in the occurrence of TTS?

Conflicts of interest

None declared.

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